

Beginning Billing Workshop Waiver

Colorado Medicaid
2014





Centers for
Medicare &
Medicaid
Services

Department of
Health Care Policy
and Financing



Medicaid

Medicaid/CHP+
Medical Providers



Xerox State
Healthcare

Training Objectives

- Billing Pre-Requisites
 - National Provider Identifier (NPI)
 - What it is and how to obtain one
 - Eligibility
 - How to verify
 - Know the different types
- Billing Basics
 - How to ensure your claims are timely
 - When to use the CMS 1500 paper claim form
 - How to bill when other payers are involved



What is an NPI?

- National Provider Identifier
- Unique 10-digit identification number issued to U.S. health care providers by CMS
- All HIPAA covered health care providers/organizations must use NPI in all billing transactions
- Are permanent once assigned
 - Regardless of job/location changes



What is an NPI?

- How to Obtain & Learn Additional Information:
 - CMS web page (paper copy)-
 - www.dms.hhs.gov/nationalproidentstand/
 - National Plan and Provider Enumeration System (NPPES)-
 - www.nppes.cms.hhs.gov
 - Enumerator-
 - 1-800-456-3203
 - 1-800-692-2326 TTY
 - **Waiver Provider currently do not require a NPI**



NEW! Department Website

1.

<https://www.colorado.gov/hcpf>

www.colorado.gov/hcpf

COLORADO

Department of Health Care
Policy & Financing

Home

For Our Members

For Our Providers

For Our Stakeholders

For Our Partners

2.

For Our Providers

We administer Medicaid, Child Health Plan *Plus*, and other health care programs for Coloradans who qualify.

Explore
Benefits



Apply
Now



Find
Doctors



Get
Help



Feeling Sick?

For medical advice, call the Nurse Line:

800-283-3221



**Get Covered.
Stay Healthy.**

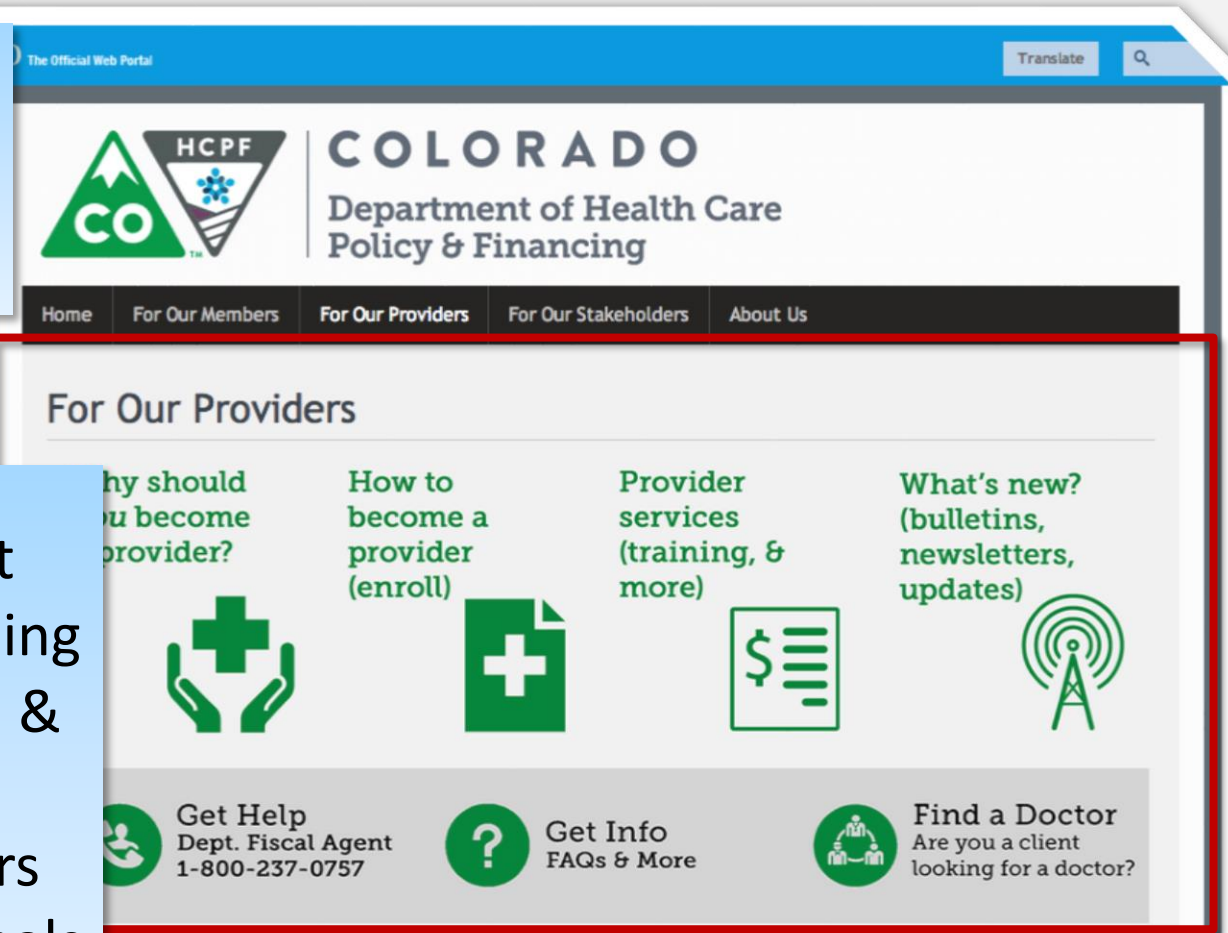
colorado.gov/health

NEW! Provider Home Page

Find what
you need
here



Contains important
information regarding
Colorado Medicaid &
other topics of
interest to providers
& billing professionals



Provider Enrollment

Question:

What does Provider Enrollment do?



Answer:

Enrolls providers into the Colorado Medical Assistance Program, not members

Question:

Who needs to enroll?



Answer:

Everyone who provides services for Medical Assistance Program members



Billing Provider Number

Billing Provider

- Entity being reimbursed for service



Verifying Eligibility

- Always print & save copy of eligibility verifications
- Keep eligibility information in member's file for auditing purposes
- Ways to verify eligibility:



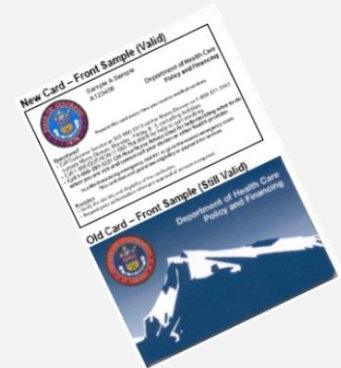
Web Portal



Fax Back
1-800-493-0920



CMERS/AVRS
1-800-237-0757



Medicaid ID Card
with Switch
Vendor

Eligibility Response Information

- Eligibility Dates
- Co-Pay Information
- Third Party Liability (TPL)
- Prepaid Health Plan
- Medicare
- Special Eligibility
- BHO
- Guarantee Number



Eligibility Request Response (271)

[Print](#)[Return To Eligibility Inquiry](#)

Eligibility Request

Provider ID: National:

From DOS: Through:

Client Detail

State ID: DOB:

Last Name: First:

CO MEDICAL ASSISTANT

Response Creation Date & Time: 05/06/2011 10:00:00 AM

[Contact Information for Questions or Comments](#)

Provider Relations Number: 800-237-2000

[Requesting Provider](#)

Provider ID: Name:

[Client Details](#)

Name: State ID:

[Client Eligibility Details](#)

Eligibility Status: **Eligible**

Eligibility Benefit Date: 04/06/2011 - 04/06/2011

Guarantee Number: **111400000000**

Coverage Name: Medicaid

PREPAID HEALTH PLAN OR ACCOUNTABLE CARE COLLABORATIVE

Eligibility Benefit Date: 04/06/2011 - 04/06/2011

Messages:

[MHPROV Services](#)

Provider Name: **COLORADO HEALTH PARTNERSHIPS LLC**

Provider Contact Phone Number: 800-804-5008

Information appears in sections (Requesting Provider, Member Details, Member Eligibility Details, etc.). Use the scroll bar to the right to view more details.

A successful inquiry notes a Guarantee Number. Print a copy of the response for the member's file when necessary.

As a reminder, information received is based on what is available through the Colorado Benefits Management System (CBMS). Updates may take up to 72 hours.



Medicaid Identification Cards

- Both cards are valid
- Identification Card does not guarantee eligibility



Billing Overview

- Record Retention
- Claim submission
- Prior Authorization Requests (PARs)
- Timely filing
- Extensions for timely filing



Record Retention

- Providers must:
 - Maintain records for at least 6 years
 - Longer if required by:
 - Regulation
 - Specific contract between provider & Colorado Medical Assistance Program
 - Furnish information upon request about payments claimed for Colorado Medical Assistance Program services



Record Retention

- Medical records must:
 - Substantiate submitted claim information
 - Be signed & dated by person ordering & providing the service
 - Computerized signatures & dates may be used if electronic record keeping system meets Colorado Medical Assistance Program security requirements

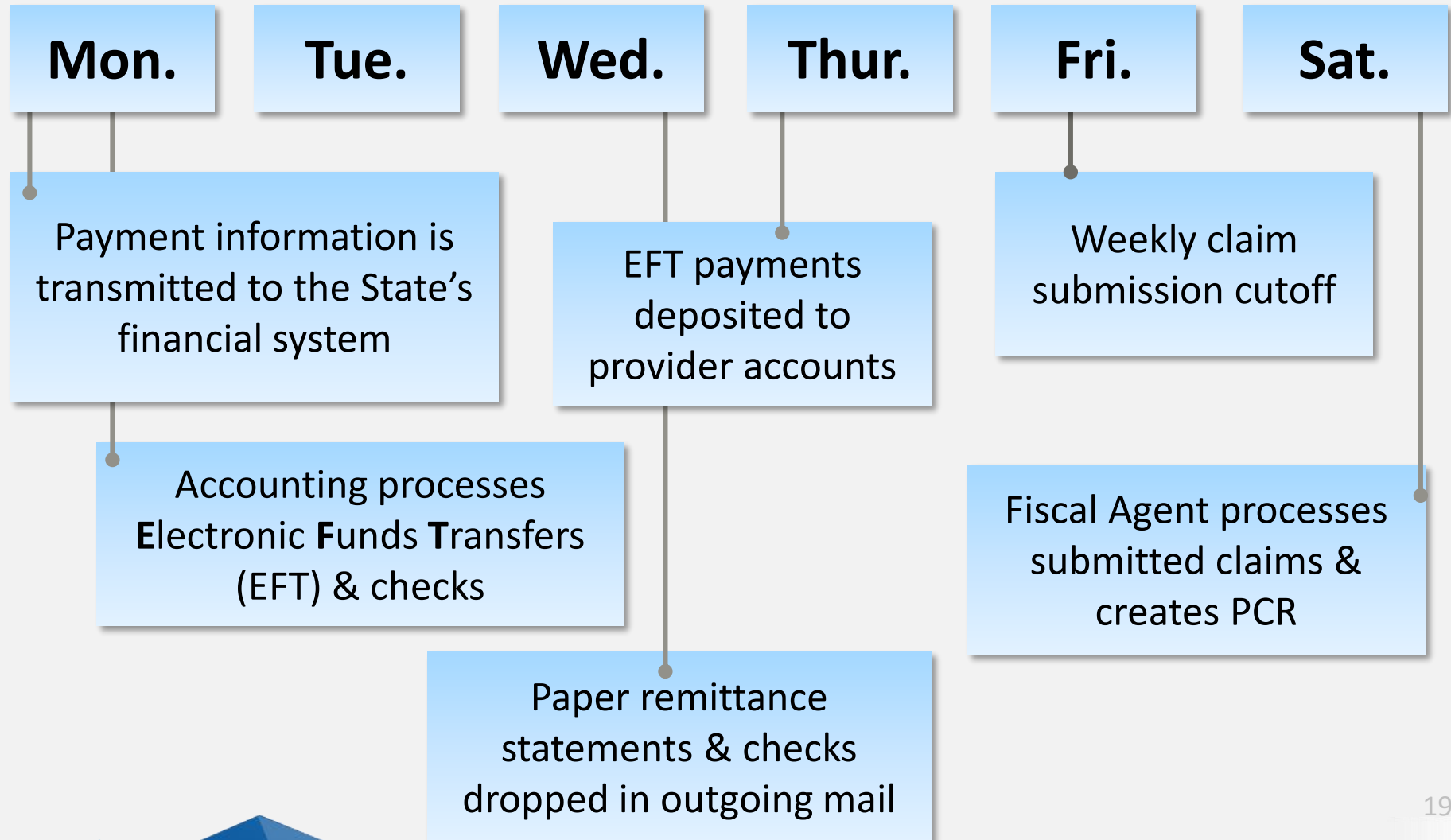


Submitting Claims

- Methods to submit:
 - Electronically through **Web Portal**
 - Electronically using **Batch Vendor, Clearinghouse, or Billing Agent**
 - **Paper** only when
 - Pre-approved (consistently submits less than 5 per month)
 - Claims require attachments



Payment Processing Schedule



Electronic Funds Transfer (EFT)

- Several Advantages:

- Free!
- No postal service delays
- Automatic deposits every Friday
- Safest, fastest & easiest way to receive payments
- Located in Provider Services Forms section on Department website



Waiver PARs

CCB



Adult w/ DHS Waivers

- Supported Living Services (SLS)
- Developmentally Disabled (DD)
- Children's Extensive Support (CES)
- Day Habilitation Services and Support (DHSS)

CMA / SEP



Adult with or without HCPF Waivers

- Elderly Blind and Disabled (EBD)
- Community Mental Health Services (CMHS)
- Brain Injury (BI)
- Spinal Cord Injury (SCI)
- Children with Life Limiting Illness (CLLI)
- Children With Autism (CWA)
- Children's Home Community Based Services (CHCBS)



Prior Authorization Flow

1



Case Managers evaluate all members for functional eligibility for all long term care services

2



Complete Prior Approval and/or Cost Containment Requests (PARs) for all services under HCBS waiver programs

3



Submit copy of reviewed PAR to provider and to the Fiscal Agent

4



Fiscal Agent keys PAR into MMIS and transmits PAR letter back to Case Manager via the FRS

5



Case Manager sends PAR letter to provider

6



Provider bills claim for approved services



Waiver Prior Authorization Form

STATE OF COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING					
REQUEST FOR ADULT HOME AND COMMUNITY BASED SERVICES (HCBS) PRIOR APPROVAL AND COST CONTAINMENT					CMHS- UA
HCBS - Community Mental Health Supports (CMHS) Waiver					PA Number being revised:
					Revision? <input type="checkbox"/> Yes <input type="checkbox"/> No
1. CLIENT NAME	2. CLIENT ID	3. SEX	4. BIRTHDATE		
		<input type="checkbox"/> M <input type="checkbox"/> F			
5. REQUESTING PROVIDER #	6. CLIENT'S COUNTY	7. CASE NUMBER (AGENCY USE)		8. DATES COVERED	
				From: Through:	
STATEMENT OF REQUESTED SERVICES					
9. Description	10. Provider	11. Modifier	12. Max Units	13. Cost Per Unit	14. Total \$ Authorize
S5105 Adult Day Services, Basic (UA)					
S5105 Adult Day Services, Specialized (UA)		TF			
T2031 Alternative Care Facility (ACF) (UA)					
T2025 CDASS (Cent/Unit) (UA)					
T2040 CDASS Per Member/Per Month (PM/PM) (UA)					
S5165 Home Modifications (UA)					
S5130 Homemaker (UA)					
T2029 Medication Reminder, Install/Purchase (UA)					
S5185 Medication Reminder, Monitoring (UA)					
A0100 NMT, Taxi (UA)					
A0120 NMT, Mobility Van	Mileage Band 1(0-10 miles) (UA)				
A0120 NMT, Mobility Van	Mileage Band 1(0-10 miles) (UA)				
To and From Adult Day		HB			
A0130 NMT, Wheelchair	Mileage Band 1(0-10 miles) (UA)				
A0130 NMT, Wheelchair	Mileage Band 1(0-10 miles) (UA)				
Van To and From Adult Day		HB			
T1019 Personal Care (UA)					
T1019 Personal Care, Relative (UA)		HR			
S5160 Personal Emergency Response System (PERs)					
S5161 PERs, Monitoring (UA)					
S5151 Respite Care, ACF (UA)					
H0045 Respite Care, NF (UA)					
A					

BI
CMHS
EBD
PLWA
CHCBS
CLLI
CWA
+

- Find Adult HCBS Prior Approval and Cost Containment workbook for Waiver programs on the Department's website

➤ www.colorado.gov/hcpf

- Provider Services → Forms → Prior Authorization Request



Timely Filing – Medicare/Medicaid Enrollees

Medicare pays claim



- 120 days from Medicare payment date

Medicare denies claim



- 60 days from Medicare denial date



Transaction Control Number

Receipt Method

0 = Paper
2 = Medicare Crossover
3 = Electronic
4 = System Generated

Batch Number

Document Number

0 14 129 00 150 0 00037

Year of Receipt

Julian Date of Receipt

Adjustment Indicator

1 = Recovery
2 = Repayment



Timely Filing

- 120 days from Date of Service (DOS)
 - Determined by date of receipt, not postmark
 - PARs are not proof of timely filing
 - Certified mail is not proof of timely filing
 - Example – DOS January 1, 20XX:
 - Julian Date: 1
 - Add: 120
 - Julian Date = 121
 - Timely Filing = Day 121 (May 1st)



Timely Filing

From “through” DOS

- Nursing Facility
- Home Health
- Waiver
- In- & Outpatient
- UB-04 Services

From DOS

- FQHC Separately Billed and additional Services

From delivery date

- Obstetrical Services
- Professional Fees
- Global Procedure Codes:
 - Service Date = Delivery Date



Documentation for Timely Filing

- 60 days from date on:
 - Provider Claim Report (PCR) Denial
 - Rejected or Returned Claim
 - Use delay reason codes on 837P transaction
 - Keep supporting documentation
- Paper Claims
 - CMS 1500- Note the Late Bill Override Date (LBOD) & the date of the last adverse action in Field 19 (Additional Claim Information)



Timely Filing Extensions

- Extensions may be allowed when:
 - Commercial insurance has yet to pay/deny
 - Delayed member eligibility notification
 - Delayed Eligibility Notification Form
 - Backdated eligibility
 - Load letter from county



Extensions – Commercial Insurance

- 365 days from DOS
- 60 days from payment/denial date
- When nearing the 365 day cut-off:
 - File claim with Colorado Medicaid
 - Receive denial or rejection
 - Continue re-filing every 60 days until insurance information is available



Extensions – Delayed Notification

- 60 days from eligibility notification date
 - Certification & Request for Timely Filing Extension – Delayed Eligibility Notification Form
 - Located in Forms section
 - Complete & retain for record of LBOD
- Bill electronically
 - If paper claim required, submit with copy of Delayed Eligibility Notification Form
- Steps you can take:
 - Review past records
 - Request billing information from member



Extensions – Backdated Eligibility

- 120 days from date county enters eligibility into system
- Report by obtaining State-authorized letter identifying:
 - County technician
 - Member name
 - Delayed or backdated
 - Date eligibility was updated



CMS 1500

Who completes the CMS 1500?

HCBS/Waiver
providers

CMS 1500



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

<input type="checkbox"/> PICA		<input type="checkbox"/> PICA	
1. MEDICARE <input type="checkbox"/> (Medicare) MEDICAID <input type="checkbox"/> (Medicaid) TRICARE <input type="checkbox"/> (DoD) CHAMPVA <input type="checkbox"/> (Member ID) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA <input type="checkbox"/> (ID#) RAILROAD <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)		1a. INSURED'S ID. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
4. INSURED'S NAME (Last Name, First Name, Middle Initial)		5. INSURED'S ADDRESS (No., Street)	
6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)	
8. RESERVED FOR NUCC USE		9. RESERVED FOR NUCC USE	
10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/>		12. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State)		13. OTHER CLAIM ID (Designated by NUCC)	
c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>		14. INSURANCE PLAN NAME OR PROGRAM NAME	
15. CLAIM CODES (Designated by NUCC)		16. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, complete items 9, 9a, and 9d.	
17. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.)			
18. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.)			
19. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY QUAL		20. OTHER DATE QUAL MM DD YY	
21. NAME OF REFERRING PROVIDER OR OTHER SOURCE		22. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
23. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		24. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES	
25. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate to service line below (24E)) ICD 9d.		26. RESUBMISSION CODE ORIGINAL REF. NO.	
27. PRIOR AUTHORIZATION NUMBER		28. DATE(S) OF SERVICE FROM MM DD YY TO MM DD YY	
29. F. \$ CHARGES		30. G. \$ CHARGES	
31. H. \$ CHARGES		32. I. \$ CHARGES	
33. J. \$ CHARGES		34. K. \$ CHARGES	
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373. ML. \$ CHARGES		374. MM. \$ CHARGES	
375. MN. \$ CHARGES		376. MO. \$ CHARGES	
377. MP. \$ CHARGES		378. MQ. \$ CHARGES	
379. MR. \$ CHARGES		380. MS. \$ CHARGES	
381. MT. \$ CHARGES		382. MU. \$ CHARGES	
383. MV. \$ CHARGES		384. MW. \$ CHARGES	
385. MX. \$ CHARGES		386. MY. \$ CHARGES	
387. MZ. \$ CHARGES		388. NA. \$ CHARGES	
389. NB. \$ CHARGES		390. NC. \$ CHARGES	
391. ND. \$ CHARGES		392. NE. \$ CHARGES	
393. NF. \$ CHARGES		394. NG. \$ CHARGES	
395. NH. \$ CHARGES		396. NI. \$ CHARGES	
397. NJ. \$ CHARGES		398. NK. \$ CHARGES	
399. NL. \$ CHARGES		400. NM. \$ CHARGES	
401. NN. \$ CHARGES		402. NO. \$ CHARGES	
403. NP. \$ CHARGES		404. NQ. \$ CHARGES	
405. NR. \$ CHARGES		406. NS. \$ CHARGES	
407. NT. \$ CHARGES		408. NU. \$ CHARGES	
409. NV. \$ CHARGES		410. NW. \$ CHARGES	
411. NX. \$ CHARGES		412. NY. \$ CHARGES	
413. NZ. \$ CHARGES		414. OA. \$ CHARGES	
415. OB. \$ CHARGES		416. OC. \$ CHARGES	
417. OD. \$ CHARGES		418. OE. \$ CHARGES	
419. OF. \$ CHARGES		420. OG. \$ CHARGES	
421. OH. \$ CHARGES		422. OI. \$ CHARGES	
423. OJ. \$ CHARGES			

CMS 1500 Field Number	1
Field Title	Medicare, Medicaid, TRICARE, CHAMPVA, Group Health Plan, FECA, Black Lung, Other
Requirement	Required
Instructions	Indicate the type of health insurance coverage applicable to this claim by placing an "X" in the appropriate box. Only one box can be marked.

1. MEDICARE <input type="checkbox"/> (Medicare#)	MEDICAID <input type="checkbox"/> (Medicaid#)	TRICARE <input type="checkbox"/> (ID#/DoD#)	CHAMPVA <input type="checkbox"/> (Member ID#)	GROUP HEALTH PLAN <input type="checkbox"/> (ID#)	FECA BLACK LUNG <input type="checkbox"/> (ID#)	OTHER <input type="checkbox"/> (ID#)	1a. INSURED'S ID, NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last name, First Name, Middle Initial)				3. PATIENT'S BIRTH DATE MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last name, First name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street) CITY STATE				6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) CITY STATE	
8. RESERVED FOR NUCC USE							

1. MEDICARE <input type="checkbox"/> (Medicare#)	MEDICAID <input type="checkbox"/> (Medicaid#)	TRICARE <input type="checkbox"/> (ID#/DoD#)	CHAMPVA <input type="checkbox"/> (Member ID#)	GROUP HEALTH PLAN <input type="checkbox"/> (ID#)	FECA BLACK LUNG <input type="checkbox"/> (ID#)	OTHER <input type="checkbox"/> (ID#)
---	--	--	--	---	--	---

a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO	a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) <input type="text"/>	b. OTHER CLAIM ID (Designated by NUCC) <input type="text"/>
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	c. INSURANCE PLAN NAME OR PROGRAM NAME <input type="text"/>
d. INSURANCE PLAN NAME OR PROGRAM NAME <input type="text"/>	10d. CLAIM CODES (Designated by NUCC) <input type="text"/>	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____



CMS 1500 Field Number	1a
Field Title	Insured's ID Number
Requirement	Required
Instructions	Enter the insured's ID number as shown on insured's ID card for the payer to which the claim is being submitted.

1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA <input type="checkbox"/> (ID#) LUNG <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)		1a. INSURED'S ID NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE (MM/DD/YY) SEX M <input type="checkbox"/> F <input type="checkbox"/>
5. PATIENT'S ADDRESS (No., Street)		4. INSURED'S NAME (Last name, First name, Middle Initial)
6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)
CITY	STATE	CITY
ZIP CODE		STATE (a Code)
8. OTHER INSURANCE		
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO	a. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX M <input type="checkbox"/> F <input type="checkbox"/>
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) <input type="text"/>	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED _____ DATE _____		SIGNED _____



CMS 1500 Field Number	2
Field Title	Patient's Name
Requirement	Required
Instructions	Enter the patient's full last name, first name, and middle initial. If the patient uses a last name suffix (e.g., Jr, Sr), enter it after the last name and before the first name.

1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA <input type="checkbox"/> (ID#) LUNG <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)		1a. INSURED'S ID, NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last name, First Name, Middle Initial)		4. INSURED'S NAME (Last Name, First name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street)		7. INSURED'S ADDRESS (No., Street)	
CITY		CITY	
STATE		STATE	
ZIP CODE		Area Code	
3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
8. RESERVED FOR NUCC USE		9. RESERVED FOR NUCC USE	
10. OTHER INSURED'S		11. RESERVED FOR NUCC USE	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO	
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) <input type="text"/>	
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (Designated by NUCC)	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.	
SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____	

CMS 1500 Field Number	3
Field Title	Patient's Birth Date, Sex
Requirement	Required
Instructions	Enter the patient's eight-digit birth date MM/DD/YY). Place an "X" in the correct box to indicate the sex (gender) of the patient.

1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA <input type="checkbox"/> (ID#) SEX <input type="checkbox"/> (ID#) LUNG <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)		1a. INSURED'S LD, NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
CITY	3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>		STATE
ZIP CODE	TELEPHONE ()	TELEPHONE (Include Area Code) ()	
5. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO	
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) <input type="text"/>	
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (Designated by NUCC)	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.		11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.	
SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____	



CMS 1500 Field Number	4
Field Title	Insured's Name
Requirement	Not Required
Instructions	

1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA <input type="checkbox"/> (ID#) FECA LUNG <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)		1a. INSURED'S LD, NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE (MM/DD/YY) SEX M <input type="checkbox"/> F <input type="checkbox"/>
5. PATIENT'S ADDRESS (No., Street)		4. INSURED'S NAME (Last name, First name, Middle Initial)
CITY	STATE	7. INSURED'S ADDRESS (No., Street)
ZIP CODE	TELEPHONE (Include Area Code) ()	CITY
		STATE
5. RESERVED FOR NUCC USE		ZIP CODE
		TELEPHONE (Include Area Code) ()
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) <input type="text"/>
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (Designated by NUCC)
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.		11. INSURED'S POLICY GROUP OR FECA NUMBER
SIGNED _____ DATE _____		a. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX M <input type="checkbox"/> F <input type="checkbox"/>
		b. OTHER CLAIM ID (Designated by NUCC)
		c. INSURANCE PLAN NAME OR PROGRAM NAME
		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.
		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
		SIGNED _____



CMS 1500 Field Number	5
Field Title	Patient's Address
Requirement	Not Required
Instructions	

1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA <input type="checkbox"/> (ID#) FECA LUNG <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)		1a. INSURED'S LD, NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE (MM DD YY) SEX M <input type="checkbox"/> F <input type="checkbox"/>
5. PATIENT'S ADDRESS (No., Street)		4. INSURED'S NAME (Last name, First name, Middle Initial)
CITY	STATE	7. INSURED'S ADDRESS (No., Street)
ZIP CODE	TELEPHONE (Include Area Code) ()	CITY
		STATE
5. RESERVED FOR NUCC USE		ZIP CODE
		TELEPHONE (Include Area Code) ()
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. INSURED'S DATE OF BIRTH (MM DD YY) SEX M <input type="checkbox"/> F <input type="checkbox"/>
b. RESERVED FOR NUCC USE		b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE		c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) <input type="text"/> c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO 10d. CLAIM CODES (Designated by NUCC)		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		SIGNED _____



CMS 1500 Field Number	6
Field Title	Patient's Relationship to Insured
Requirement	Not Required
Instructions	

1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA <input type="checkbox"/> (ID#) FECA LUNG <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)		1a. INSURED'S LD, NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>
5. PATIENT'S ADDRESS (No., Street)		4. INSURED'S NAME (Last name, First name, Middle Initial)
6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)
CITY	STATE	CITY
ZIP CODE	TELEPHONE (Include Area Code) ()	ZIP CODE
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	5. RESERVED FOR NUCC USE	STATE
a. OTHER INSURED'S POLICY OR GROUP NUMBER	10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) <input type="text"/> c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> b. OTHER CLAIM ID (Designated by NUCC) <input type="text"/> c. INSURANCE PLAN NAME OR PROGRAM NAME
b. RESERVED FOR NUCC USE	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.
c. RESERVED FOR NUCC USE		
d. INSURANCE PLAN NAME OR PROGRAM NAME		
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____



CMS 1500 Field Number	7
Field Title	Insured's Address
Requirement	Not Required
Instructions	

1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)		1a. INSURED'S LD, NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE (MM DD YY) SEX M <input type="checkbox"/> F <input type="checkbox"/>
5. PATIENT'S ADDRESS (No., Street)		4. INSURED'S NAME (Last name, First name, Middle Initial)
CITY	STATE	7. INSURED'S ADDRESS (No., Street)
ZIP CODE	TELEPHONE (Include Area Code) ()	CITY
		STATE
5. RESERVED FOR NUCC USE		ZIP CODE
		TELEPHONE (Include Area Code) ()
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. INSURED'S DATE OF BIRTH (MM DD YY) SEX M <input type="checkbox"/> F <input type="checkbox"/>
b. RESERVED FOR NUCC USE		b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE		c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.		
SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____



CMS 1500 Field Number	8
Field Title	Reserved for NUCC Use
Requirement	
Instructions	

1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA <input type="checkbox"/> (ID#) FECA BEN LUNG <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)		1a. INSURED'S LD, NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>
CITY	STATE	7. INSURED'S ADDRESS (No., Street)
ZIP CODE	TELEPHONE (Include Area Code) ()	CITY
		STATE
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) <input type="text"/>
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (Designated by NUCC)
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.		11. INSURED'S POLICY GROUP OR FECA NUMBER
SIGNED _____ DATE _____		a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>
		b. OTHER CLAIM ID (Designated by NUCC)
		c. INSURANCE PLAN NAME OR PROGRAM NAME
		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.
		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
		SIGNED _____

CMS 1500 Field Number	9
Field Title	Other Insured's Name
Requirement	Not Required
Instructions	

1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)		1a. INSURED'S LD, NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE (MM/DD/YY) SEX M <input type="checkbox"/> F <input type="checkbox"/>
5. PATIENT'S ADDRESS (No., Street)		4. INSURED'S NAME (Last name, First name, Middle Initial)
CITY	STATE	7. INSURED'S ADDRESS (No., Street)
ZIP CODE	TELEPHONE (Include Area Code) ()	CITY
		STATE
5. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>
a. OTHER INSURED'S POLICY OR GROUP NUMBER		5. RESERVED FOR NUCC USE
b. RESERVED FOR NUCC USE		10. IS PATIENT'S CONDITION RELATED TO:
c. RESERVED FOR NUCC USE		a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/>
d. INSURANCE PLAN NAME OR PROGRAM NAME		b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) <input type="text"/>
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.		11. INSURED'S POLICY GROUP OR FECA NUMBER
SIGNED _____ DATE _____		a. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX M <input type="checkbox"/> F <input type="checkbox"/>
		b. OTHER CLAIM ID (Designated by NUCC)
		c. INSURANCE PLAN NAME OR PROGRAM NAME
		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, complete items 9, 9a, and 9d.
		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
		SIGNED _____

CMS 1500 Field Number	9a
Field Title	Other Insured's Policy or Group Number
Requirement	Not Required
Instructions	

1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)		1a. INSURED'S LD, NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE (MM/DD/YY) SEX M <input type="checkbox"/> F <input type="checkbox"/>
5. PATIENT'S ADDRESS (No., Street)		4. INSURED'S NAME (Last name, First name, Middle Initial)
CITY	STATE	7. INSURED'S ADDRESS (No., Street)
ZIP CODE	TELEPHONE (Include Area Code) ()	CITY
		STATE
5. RESERVED FOR NUCC USE		7. RESERVED FOR NUCC USE
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) ()
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (Designated by NUCC)
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.		11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX M <input type="checkbox"/> F <input type="checkbox"/> b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.
SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____

CMS 1500 Field Number	9b
Field Title	Reserved for NUCC Use
Requirement	Not Required
Instructions	

1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)		1a. INSURED'S LD, NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE (MM/DD/YY) SEX M <input type="checkbox"/> F <input type="checkbox"/>
5. PATIENT'S ADDRESS (No., Street)		4. INSURED'S NAME (Last name, First name, Middle Initial)
CITY	STATE	7. INSURED'S ADDRESS (No., Street)
ZIP CODE	TELEPHONE (Include Area Code) ()	CITY
		STATE
5. RESERVED FOR NUCC USE		ZIP CODE
		TELEPHONE (Include Area Code) ()
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX M <input type="checkbox"/> F <input type="checkbox"/>
b. RESERVED FOR NUCC USE		b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE		c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>PLACE (State)</i> c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO 10d. CLAIM CODES (Designated by NUCC)		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		SIGNED _____

CMS 1500 Field Number	9c
Field Title	Reserved for NUCC Use
Requirement	Not Required
Instructions	

1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA <input type="checkbox"/> (ID#) FECA LUNG <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)		1a. INSURED'S LD, NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE (MM DD YY) SEX M <input type="checkbox"/> F <input type="checkbox"/>
5. PATIENT'S ADDRESS (No., Street)		4. INSURED'S NAME (Last name, First name, Middle Initial)
CITY	STATE	7. INSURED'S ADDRESS (No., Street)
ZIP CODE	TELEPHONE (Include Area Code) ()	CITY
		STATE
5. RESERVED FOR NUCC USE		ZIP CODE
		TELEPHONE (Include Area Code) ()
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. INSURED'S DATE OF BIRTH (MM DD YY) SEX M <input type="checkbox"/> F <input type="checkbox"/>
b. RESERVED FOR NUCC USE		b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE		c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>PLACE (State)</i> c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO 10d. CLAIM CODES (Designated by NUCC)		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		SIGNED _____

CMS 1500 Field Number	9d
Field Title	Insurance Plan Name or Program Name
Requirement	Not Required
Instructions	

1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)		1a. INSURED'S ID, NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE (MM/DD/YY) SEX M <input type="checkbox"/> F <input type="checkbox"/>
5. PATIENT'S ADDRESS (No., Street)		4. INSURED'S NAME (Last name, First name, Middle Initial)
CITY	STATE	7. INSURED'S ADDRESS (No., Street)
ZIP CODE	TELEPHONE (Include Area Code) ()	CITY
		STATE
5. RESERVED FOR NUCC USE		ZIP CODE
		TELEPHONE (Include Area Code) ()
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX M <input type="checkbox"/> F <input type="checkbox"/>
b. RESERVED FOR NUCC USE		b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE		c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>PLACE (State)</i> c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO 10d. CLAIM CODES (Designated by NUCC)		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		SIGNED _____

CMS 1500 Field Number	10a-c
Field Title	Is Patient's Condition Related To:
Requirement	Not Required
Instructions	

1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)		1a. INSURED'S LD, NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE (MM DD YY) SEX M <input type="checkbox"/> F <input type="checkbox"/>
5. PATIENT'S ADDRESS (No., Street)		4. INSURED'S NAME (Last name, First name, Middle Initial)
CITY	STATE	7. INSURED'S ADDRESS (No., Street)
ZIP CODE	TELEPHONE (Include Area Code) ()	CITY
		STATE
5. RESERVED FOR NUCC USE		ZIP CODE
		TELEPHONE (Include Area Code) ()
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. INSURED'S DATE OF BIRTH (MM DD YY) SEX M <input type="checkbox"/> F <input type="checkbox"/>
b. RESERVED FOR NUCC USE		b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE		c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.		
SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____

CMS 1500 Field Number	10d
Field Title	Reserved for Local Use
Requirement	Not Required
Instructions	

1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)		1a. INSURED'S LD, NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE (MM DD YY) SEX M <input type="checkbox"/> F <input type="checkbox"/>
5. PATIENT'S ADDRESS (No., Street)		4. INSURED'S NAME (Last name, First name, Middle Initial)
CITY	STATE	7. INSURED'S ADDRESS (No., Street)
ZIP CODE	TELEPHONE (Include Area Code) ()	CITY
		STATE
5. RESERVED FOR NUCC USE		ZIP CODE
		TELEPHONE (Include Area Code) ()
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. INSURED'S DATE OF BIRTH (MM DD YY) SEX M <input type="checkbox"/> F <input type="checkbox"/>
b. RESERVED FOR NUCC USE		b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE		c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.		
SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____

CMS 1500 Field Number	11
Field Title	Insured's Policy, Group, or FECA Number
Requirement	Not Required
Instructions	

1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)		1a. INSURED'S ID. NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>
5. PATIENT'S ADDRESS (No., Street)		7. INSURED'S ADDRESS (No., Street)
CITY	STATE	CITY
ZIP CODE	TELEPHONE (Include Area Code) ()	ZIP CODE
TELEPHONE (Include Area Code) ()		
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO	
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) <input type="text"/>	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.		11. INSURED'S POLICY, GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO // yes, complete items 9, 9a, and 9d.
SIGNED _____ DATE _____		SIGNED _____



CMS 1500 Field Number	11a
Field Title	Insured's Date of Birth, Sex
Requirement	Not Required
Instructions	

1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA <input type="checkbox"/> (ID#) LUNG <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)		1a. INSURED'S LD, NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE (MM DD YY) SEX (M <input type="checkbox"/> F <input type="checkbox"/>)
5. PATIENT'S ADDRESS (No., Street)		4. INSURED'S NAME (Last name, First name, Middle Initial)
CITY	STATE	7. INSURED'S ADDRESS (No., Street)
ZIP CODE	TELEPHONE (Include Area Code) ()	CITY
5. RESERVED FOR NUCC USE		STATE
5. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	10. IS PATIENT'S CONDITION RELATED TO:	a. INSURED'S DATE OF BIRTH (MM DD YY) SEX (M <input type="checkbox"/> F <input type="checkbox"/>)
b. RESERVED FOR NUCC USE	a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) ()	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.
10d. CLAIM CODES (Designated by NUCC)		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		SIGNED _____



CMS 1500 Field Number	11b
Field Title	Other Claim ID
Requirement	Not Required
Instructions	

1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)		1a. INSURED'S LD, NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE (MM DD YY) SEX M <input type="checkbox"/> F <input type="checkbox"/>
5. PATIENT'S ADDRESS (No., Street)		4. INSURED'S NAME (Last name, First name, Middle Initial)
CITY	STATE	7. INSURED'S ADDRESS (No., Street)
ZIP CODE	TELEPHONE (Include Area Code) ()	CITY
		STATE
5. RESERVED FOR NUCC USE		ZIP CODE
		TELEPHONE (Include Area Code) ()
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. INSURED'S DATE OF BIRTH (MM DD YY) SEX M <input type="checkbox"/> F <input type="checkbox"/>
b. RESERVED FOR NUCC USE		b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE		c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>PLACE (State)</i> c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO 10d. CLAIM CODES (Designated by NUCC)		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		SIGNED _____

CMS 1500 Field Number	11c
Field Title	Insurance Plan Name or Program Name
Requirement	Not Required
Instructions	

1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA <input type="checkbox"/> (ID#) FECA LUNG <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)		1a. INSURED'S LD, NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE (MM DD YY) SEX M <input type="checkbox"/> F <input type="checkbox"/>
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>
CITY	STATE	7. INSURED'S ADDRESS (No., Street)
ZIP CODE	TELEPHONE (Include Area Code) ()	CITY
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		9. RESERVED FOR NUCC USE
a. OTHER INSURED'S POLICY OR GROUP NUMBER		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) <input type="text"/> c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO
b. RESERVED FOR NUCC USE		11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH (MM DD YY) SEX M <input type="checkbox"/> F <input type="checkbox"/> b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE		c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (Designated by NUCC)
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.
SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____



CMS 1500 Field Number	11d
Field Title	Is there another Health Benefit Plan?
Requirement	Not Required
Instructions	

1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA <input type="checkbox"/> (ID#) FECA LUNG <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)		1a. INSURED'S LD, NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE (MM/DD/YY) SEX M <input type="checkbox"/> F <input type="checkbox"/>
5. PATIENT'S ADDRESS (No., Street)		4. INSURED'S NAME (Last name, First name, Middle Initial)
6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)
CITY	STATE	CITY
ZIP CODE	TELEPHONE (Include Area Code) ()	ZIP CODE
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) <input type="text"/> c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO 10d. CLAIM CODES (Designated by NUCC)	11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX M <input type="checkbox"/> F <input type="checkbox"/> b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME
a. OTHER INSURED'S POLICY OR GROUP NUMBER		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>
b. RESERVED FOR NUCC USE		
c. RESERVED FOR NUCC USE		
d. INSURANCE PLAN NAME OR PROGRAM NAME		
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____

CMS 1500 Field Number	12
Field Title	Patient's or Authorized Person's Signature
Requirement	Required
Instructions	Enter "Signature on File", "SOF", or legal signature. If there is no signature on file, leave blank or enter "No Signature on File". Enter the date the claim form was signed.

1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA <input type="checkbox"/> (ID#) LUNG <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)		1a. INSURED'S ID, NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
CITY	READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		STATE
ZIP CODE			Code)
8. OTHER INSURANCE			
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/>	
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____	
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (Designated by NUCC)	
		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, complete items 9, 9a, and 9d.	
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____	



CMS 1500 Field Number	13
Field Title	Insured's or Authorized Person's Signature
Requirement	Not Required
Instructions	

1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)		1a. INSURED'S LD, NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE (MM/DD/YY) SEX M <input type="checkbox"/> F <input type="checkbox"/>
5. PATIENT'S ADDRESS (No., Street)		4. INSURED'S NAME (Last name, First name, Middle Initial)
CITY	STATE	7. INSURED'S ADDRESS (No., Street)
ZIP CODE	TELEPHONE (Include Area Code) ()	CITY
5. RESERVED FOR NUCC USE		STATE
5. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		7. INSURED'S ADDRESS (No., Street)
a. OTHER INSURED'S POLICY OR GROUP NUMBER		ZIP CODE
b. RESERVED FOR NUCC USE		TELEPHONE (Include Area Code) ()
c. RESERVED FOR NUCC USE		11. INSURED'S POLICY GROUP OR FECA NUMBER
d. INSURANCE PLAN NAME OR PROGRAM NAME		a. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX M <input type="checkbox"/> F <input type="checkbox"/>
10. IS PATIENT'S CONDITION RELATED TO:		b. OTHER CLAIM ID (Designated by NUCC)
a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO		c. INSURANCE PLAN NAME OR PROGRAM NAME
b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) ()		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.
c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
10d. CLAIM CODES (Designated by NUCC)		SIGNED _____
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.		DATE _____

CMS 1500 Field Number	14
Field Title	Date of Current Illness, Injury, or Pregnancy
Requirement	Not Required
Instructions	

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL		15. OTHER DATE QUAL MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a. 17b. NPI		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)				20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate ALL to service line below (24E) ICD Ind.				22. RESUBMISSION CODE ORIGINAL REF. NO.	
A. E. I. B. F. J. C. G. K. D. H. L.					
				23. PRIOR AUTHORIZATION NUMBER	

CMS 1500 Field Number	15
Field Title	Other Date
Requirement	Not Required
Instructions	

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL		15. OTHER DATE QUAL MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a. 17b. NPI		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)				20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate ALL to service line below (24E) ICD Ind.				22. RESUBMISSION CODE ORIGINAL REF. NO.	
A. B. C. D. E. F. G. H. I. J. K. L.				23. PRIOR AUTHORIZATION NUMBER	



CMS 1500 Field Number	16
Field Title	Dates Patient Unable to Work in Current Occupation
Requirement	Not Required
Instructions	

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL		15. OTHER DATE QUAL MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a. 17b. NPI		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)				20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate ALL to service line below (24E) ICD Ind.				22. RESUBMISSION CODE ORIGINAL REF. NO.	
A. B. C. D. E. F. G. H. I. J. K. L.				23. PRIOR AUTHORIZATION NUMBER	



CMS 1500 Field Number	17
Field Title	Name of referring Provider or Other Source
Requirement	Not Required
Instructions	

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL		15. OTHER DATE QUAL MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a. 17b. NPI		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)				20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate ALL to service line below (24E) ICD Ind.				22. RESUBMISSION CODE ORIGINAL REF. NO.	
A. B. C. D. E. F. G. H. I. J. K. L.				23. PRIOR AUTHORIZATION NUMBER	



CMS 1500 Field Number	17a
Field Title	Other ID#
Requirement	Not Required
Instructions	

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL		15. OTHER DATE QUAL MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a. 17b. NPI		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)				20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate ALL to service line below (24E) ICD Ind.				22. RESUBMISSION CODE ORIGINAL REF. NO.	
A. E. I. B. F. J. C. G. K. D. H. L.	23. PRIOR AUTHORIZATION NUMBER				



CMS 1500 Field Number	17b
Field Title	NPI #
Requirement	Not Required
Instructions	

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL		15. OTHER DATE QUAL MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a. 17b. NPI		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)				20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate ALL to service line below (24E) ICD Ind.				22. RESUBMISSION CODE ORIGINAL REF. NO.	
A. B. C. D. E. F. G. H. I. J. K. L.				23. PRIOR AUTHORIZATION NUMBER	



CMS 1500 Field Number	18
Field Title	Hospitalization Dates Related to Current Services
Requirement	Not Required
Instructions	

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL		15. OTHER DATE QUAL MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a. 17b. NPI		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)				20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate ALL to service line below (24E) A. B. C. D. E. F. G. H. I. J. K. L.				22. RESUBMISSION CODE ORIGINAL REF. NO.	
				23. PRIOR AUTHORIZATION NUMBER	



CMS 1500 Field Number	19
Field Title	Additional Claim Information
Requirement	Conditional
Instructions	Use to document the Late Bill Override Date for timely filing.

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL				15. OTHER DATE QUAL MM DD YY				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE				17a. NPI				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY			
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)											
A. _____	B. _____	C. _____	D. _____	23. PRIOR AUTHORIZATION NUMBER							
E. _____	F. _____	G. _____	H. _____								
I. _____	J. _____	K. _____	L. _____								



CMS 1500 Field Number	20
Field Title	Outside Lab? \$ Charges
Requirement	Not Required
Instructions	

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL		15. OTHER DATE QUAL MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a. 17b. NPI		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)				20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate ALL to service line below (24E) ICD Ind.				22. RESUBMISSION CODE ORIGINAL REF. NO.	
A. E. I. B. F. J. G. K. D. H. L.				23. PRIOR AUTHORIZATION NUMBER	



CMS 1500 Field Number	21
Field Title	Diagnosis or Nature of Illness or Injury
Requirement	Required
Instructions	<p>Enter at least one but no more than twelve diagnosis codes based on the member's diagnosis/condition.</p> <p>Enter the applicable ICD indicator to identify which version of ICD codes is being reported.</p>

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL				15. OTHER DATE QUAL MM DD YY				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE				17a.				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY MM DD YY			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)								ICD Ind.			
A. _____		B. _____		C. _____		D. _____					
E. _____		F. _____		G. _____		H. _____					
I. _____		J. _____		K. _____		L. _____					



CMS 1500 Field Number	22
Field Title	Resubmission and/or Original Reference Number
Requirement	Conditional
Instructions	<p>List the Original reference number for the resubmitted claim.</p> <p>This field is not intended for use for original claim submissions.</p>

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL			15. OTHER DATE QUAL MM DD YY			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY					
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE			17a. 17b. NOT			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					
19. ADDITIONAL CLAIM INFORMATION			22. RESUBMISSION CODE			ORIGINAL REF. NO.			\$ CHARGES		
21. DIAGNOSIS OR NATURE OF ILLNESS A. E. I. B. F. J. G. K. D. H. L.						23. PRIOR AUTHORIZATION NUMBER			ORIGINAL REF. NO.		



CMS 1500 Field Number	23
Field Title	Prior Authorization Number
Requirement	Not Required
Instructions	

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL		15. OTHER DATE QUAL MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a. 17b. NPI		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)				20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate ALL to service line below (24E) ICD Ind.				22. RESUBMISSION CODE ORIGINAL REF. NO.	
A. E. I. B. F. J. C. G. K. D. H. L.	23. PRIOR AUTHORIZATION NUMBER				



CMS 1500 Field Number	24A
Field Title	Date(s) of Service
Requirement	Required
Instructions	Enter date(s) of service, both the “From” and “To” dates. If there is only one date of service, enter the date under “From”. Leave “To” blank or re-enter “From” date. This field allows for data to be entered in the MM/DD/YY format.

24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EP/OT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
From	To																
MM	DD	YY	MM	DD	YY												
																NPI	
																NPI	
																NPI	

CMS 1500 Field Number	24B
Field Title	Place of Service
Requirement	Required
Instructions	Enter the appropriate two-digit code from the Place of Service Code list for each item used or service performed.

24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. CPT/HCPCS	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EP/SOT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
From	To													
MM	DD	YY	MM	DD	YY	EMG								
													NPI	
													NPI	
													NPI	

CMS 1500 Field Number	24C
Field Title	EMG
Requirement	Not Required
Instructions	

24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EP/OT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
MM	DD	YY	MM	DD	YY												
																NPI	
																NPI	
																NPI	



CMS 1500 Field Number	24D
Field Title	Procedures, Services, or Supplies
Requirement	Required
Instructions	<p>Inter the CPT or HCPCS code(s) and modifier(s) from the appropriate code set in effect on the date of service.</p> <p>This field accommodates the entry of up to four two-digit modifiers.</p>

24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. ICD-9-CM	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS NUMBER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPICUT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
From	To						CPT/HCPCS	MODIFIER									
MM	DD	YY	MM	DD	YY												
																NPI	
																NPI	
																NPI	

CMS 1500 Field Number	24E
Field Title	Diagnosis Pointer
Requirement	Required
Instructions	Enter the diagnosis code reference letter as shown in Field 21 to relate the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first.

24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EP/OT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
From	To																
MM	DD	YY	MM	DD	YY												
																NPI	
																NPI	
																NPI	



CMS 1500 Field Number	24F
Field Title	\$ Charges
Requirement	Required
Instructions	Enter the usual and customary charge for the service represented by the procedure code on the detail line. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number.

24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EP/OT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
MM	DD	YY	MM	DD	YY			CPT/HCPCS	MODIFIER								
																NPI	
																NPI	
																NPI	

CMS 1500 Field Number	24G
Field Title	Days or Units
Requirement	Required
Instructions	<p>Enter the number of services provided for each procedure code.</p> <p>Enter whole numbers only- do not enter fractions or decimals.</p>

24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPICUT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
MM	DD	YY	MM	DD	YY			CPT/HCPCS	MODIFIER								
																NPI	
																NPI	
																NPI	

CMS 1500 Field Number	24H
Field Title	EPSDT/Family Plan
Requirement	Not Required
Instructions	

24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
MM	DD	YY	MM	DD	YY			CPT/HCPCS	MODIFIER								
																NPI	
																NPI	
																NPI	

CMS 1500 Field Number	24I
Field Title	ID Qualifier
Requirement	Not Required
Instructions	

24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. ICD-9-CM Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
MM	DD	YY	MM	DD	YY			CPT/HCPCS	MODIFIER								
																NPI	
																NPI	
																NPI	



CMS 1500 Field Number	24J
Field Title	Rendering Provider ID #
Requirement	Not Required
Instructions	

24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EP/SDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
MM	DD	YY	MM	DD	YY			CPT/HCPCS	MODIFIER								
																NPI	
																NPI	
																NPI	



CMS 1500 Field Number	25
Field Title	Federal Tax ID Number
Requirement	Not Required
Instructions	

25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO	28. TOTAL CHARGE \$	29. AMOUNT PAID \$	30. Rsvd for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & PH # ()		
SIGNED _____ DATE _____	a. NPI	b.	a. NPI	b.	



CMS 1500 Field Number	26
Field Title	Patient's Account Number
Requirement	Optional
Instructions	Enter the information that identifies the patient or claim in the provider's billing system.

25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO	28. TOTAL CHARGE \$	29. AMOUNT PAID \$	30. Rsvd for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & PH # ()		
	<div style="border: 1px solid red; padding: 5px; color: red; text-align: center;">26. PATIENT'S ACCOUNT NO.</div>				
SIGNED	DATE	a. NPI	b.	a. NPI	b.



CMS 1500 Field Number	27
Field Title	Accept Assignment?
Requirement	Required
Instructions	The accept assignment indicates that the provider agrees accept assignment under the terms of the payer's program.

25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO	28. TOTAL CHARGE \$	29. AMOUNT PAID \$	30. Rsvd for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION <div style="border: 1px solid red; padding: 5px; display: inline-block;">27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO</div>		33. BILLING PROVIDER INFO & PH # ()		
SIGNED	DATE	a. NPI	b.	a. NPI	b.



CMS 1500 Field Number	28
Field Title	Total Charge
Requirement	Required
Instructions	Enter the sum of all charges listed in field 24F.

25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO	28. TOTAL CHARGE \$	29. AMOUNT PAID \$	30. Rsvd for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED _____ DATE _____	32. SERVICE FACILITY LOCATION INFORMATION <div style="border: 1px solid red; padding: 5px; color: red; text-align: center;">28. TOTAL CHARGE \$</div>		33. BILLING PROVIDER INFO & PH # ()		
	a. NPI	b.	a. NPI	b.	



CMS 1500 Field Number	29
Field Title	Amount Paid
Requirement	Not Required
Instructions	

25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO	28. TOTAL CHARGE \$	29. AMOUNT PAID \$	30. Rsvd for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & PH # ()		
SIGNED _____ DATE _____	a. NPI	b.	a. NPI	b.	



CMS 1500 Field Number	30
Field Title	Rsvd for NUCC Use
Requirement	Not Required
Instructions	

25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO	28. TOTAL CHARGE \$	29. AMOUNT PAID \$	30. Rsvd for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & PH # ()		
SIGNED _____ DATE _____	a. NPI	b.	a. NPI	b.	

CMS 1500 Field Number	31
Field Title	Signature of Physician or Supplier Including Degrees or Credentials
Requirement	Required
Instructions	Each claim must bear the signature of the enrolled provider or the signature of a registered authorized agent. Enter the date the claim form was signed.

25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO	28. TOTAL CHARGE \$	29. AMOUNT PAID \$	30. Rsvd for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # ()			
SIGNED _____ DATE _____	a.	NPI _____ b.			

**31. SIGNATURE OF PHYSICIAN OR SUPPLIER
INCLUDING DEGREES OR CREDENTIALS**
(I certify that the statements on the reverse
apply to this bill and are made a part thereof.)

SIGNED _____ DATE _____

CMS 1500 Field Number	32
Field Title	Service Facility Location Information
Requirement	Not Required
Instructions	

25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO	28. TOTAL CHARGE \$	29. AMOUNT PAID \$	30. Rsvd for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & PH # ()		
SIGNED _____ DATE _____	a. NPI	b.	a. NPI	b.	



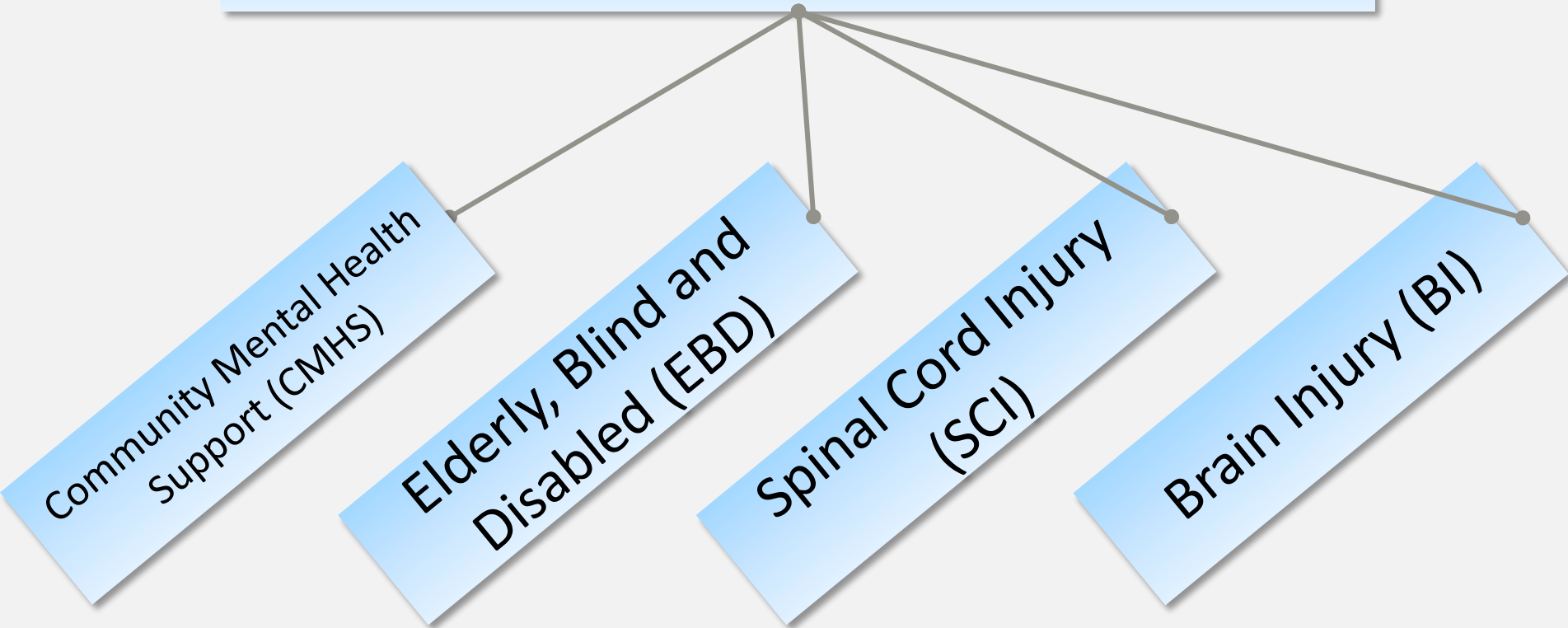
CMS 1500 Field Number	33
Field Title	Billing Provider Info & Ph #
Requirement	Required
Instructions	Enter the name of the individual or organization that will receive payment for the billed services. 33a- enter the NPI of the billing provider 33b- enter the eight-digit Colorado Medical Assistance Program provider number of the individual or organization.

25. FEDERAL TAX I.D. NUMBER	SSN EIN <input type="checkbox"/> <input type="checkbox"/>	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO	28. TOTAL CHARGE \$	29. AMOUNT PAID \$	30. Rsvd for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)		32. SERVICE FACILITY / LOCATION INFORMATION		33. BILLING PROVIDER INFO & PH # ()		
SIGNED		DATE				
		33a. NPI		33b.		



Waiver Programs

HCBS Adult Waiver Programs



Waiver Programs

Special Program Codes

Program	Modifier	Program Code
BI	U6	89
EBD	U1	82
CMHS	UA	94
CCT	UC	95
SCI	SC	M5



HCBS-BI Requirement

- Primary Purpose of Program
 - To provide a home or community based alternative to nursing facility care for persons with a diagnosis of a brain injury
- Members Served
 - Age 16 +
 - Brain injury must have occurred prior to age 65
 - Persons with a brain injury as defined in the Colorado Code of Regulations with specific DSM-IV diagnostic codes
- Level of Care Requirements
 - Nursing Facility and Hospital Level of Care



HCBS-EBD Requirement

- Primary Purpose of Program
 - The EBD program provides home or community based alternative to nursing facility care for elderly, blind, and disabled persons
- Members Served
 - Age 18 +
 - Elderly persons with a functional impairment (aged 65+)
 - Blind or physically disabled persons (aged 18-64)
- Level of Care Requirements
 - Nursing Facility Level of Care



HCBS-CMHS Requirement

- Primary Purpose of Program
 - To provide a home or community based alternative to nursing facility care for persons with a major mental illness
- Members Served
 - Age 18 +
 - Persons with a diagnosis of major mental illness as defined in the Colorado Code of Regulations with specific DSM-IV diagnostic codes
- Level of Care Requirements
 - Nursing Facility Level of Care



HCBS-SCI Requirement

- Primary Purpose of Program
 - To provide a home or community based alternative to nursing facility level of care for persons with a spinal cord injury
- Members Served
 - Age 18+
 - Persons with a spinal cord injury as defined in the Colorado Code of Regulations with specific diagnostic codes
 - Residing in the Denver/Metro area
 - Adams, Arapahoe, Douglas, Denver, Jefferson
- Level of Care Requirements
 - Nursing Facility Level or Hospital Level Care



Consumer Directed Attendant Support Services (CDASS)

- Allows BI, EBD, CMHS, SCI Adult HCBS members to direct their own care
- Delivery option provides the following for Adults:
 - Personal Care
 - Homemaker Services
 - Health Maintenance Activities



In Home Support Services (IHSS)

- Assists CHCBS, EBD & SCI Adult HCBS members in directing their own care through an agency
- Managed by an In-Home Support Services Agency
- IHSS Delivery Option provides the following for Adults:
 - Personal Care
 - Homemaker Services
 - Health Maintenance Activities
- IHSS Delivery Option provides the following for children:
 - Health Maintenance Activities



Colorado Choice Transitions (CCT)

- Helps transition Medicaid members from nursing and other long-term care (LTC) facilities back to the community
 - Participants of the program will have access to:
 - Qualified waiver services
 - Demonstration services



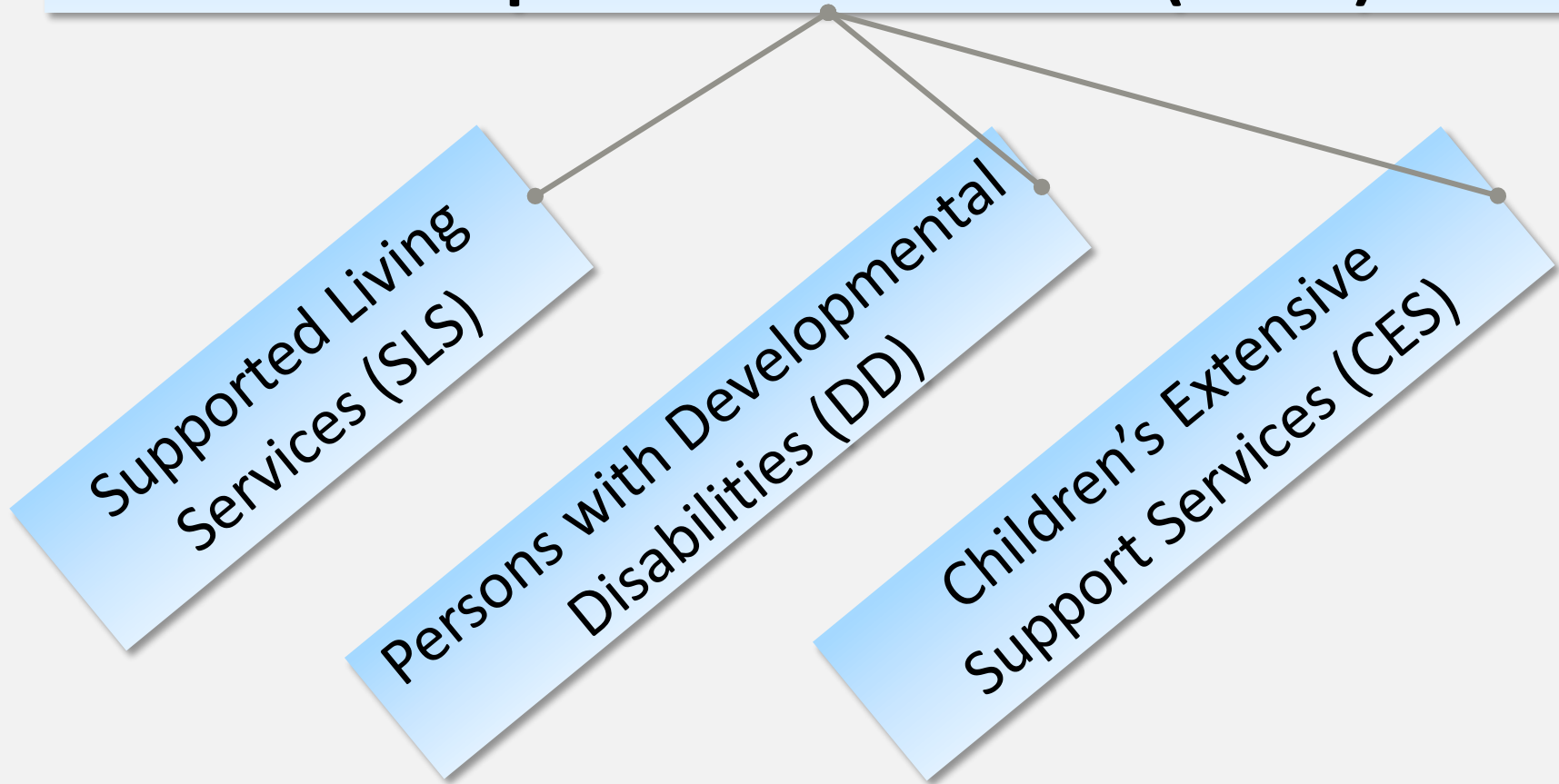
Colorado Choice Transitions (CCT)

- The CCT program compliments the:
 - Elderly, Blind and Disabled Waiver
 - Persons with Brain Injury Waiver
 - Community Mental Health Supports Waiver
 - Persons with Developmental Disabilities Wavier
 - Supported Living Services Waiver
- For more information, please visit www.colorado.gov/hcpf
 - Member's & Applicants → Long Term Care → Colorado Choice Transitions



Waiver Programs

Division of Intellectual & Developmental Disabilities (DIDD)



Waiver Programs

Special Program Codes

Program	Modifier	Program Code
DD	U3	85
SLS	U8	92
TCM	U4	87
CES	U7	90
CHRP	U9	93



HCBS-DD Requirement

- Primary Purpose of Program

- Provides persons with developmental disabilities services and support outside family home, allowing them to continue to live in the community

- Members Served

- Age 18+
- Persons who are in need of services and supports 24 hours a day that will allow them to live safely and participate in the community

- Level of Care Requirements

- Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)



HCBS-SLS Requirement

- Primary Purpose of Program
 - Provides persons with developmental disabilities services and support outside family home, allowing them to continue to live in the community
- Members Served
 - Age 18+
 - Persons who can either live independently with limited supports or who, if they need extensive supports, are already receiving that high level of support from other sources
- Level of Care Requirements
 - Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)



HCBS-CES Requirement

- Primary Purpose of Program
 - Provides care for children who are at risk of institutionalization have a diagnosis of a Developmental Disability with intense behavioral and/or medical needs
- Members Served
 - Birth through age 17
- Level of Care Requirements
 - Who meet institutional level of care for an Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID)
 - Additional program criteria needed



Waiver Programs

Department of Human Services (DHS)

Children's Habitation
Residential Program (CHRP)



Waiver Programs

Special Program Codes

Program	Modifier	Program Code
CHRP	U9	93

HCBS-CHRP Requirement

- Primary Purpose of Program
 - Provides care for foster children who are at risk of institutionalization and have a diagnosis of a Developmental Disability with extraordinary needs
- Members Served
 - Birth through age 20
- Level of Care Requirements
 - Who meet institutional level of care for an Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID)



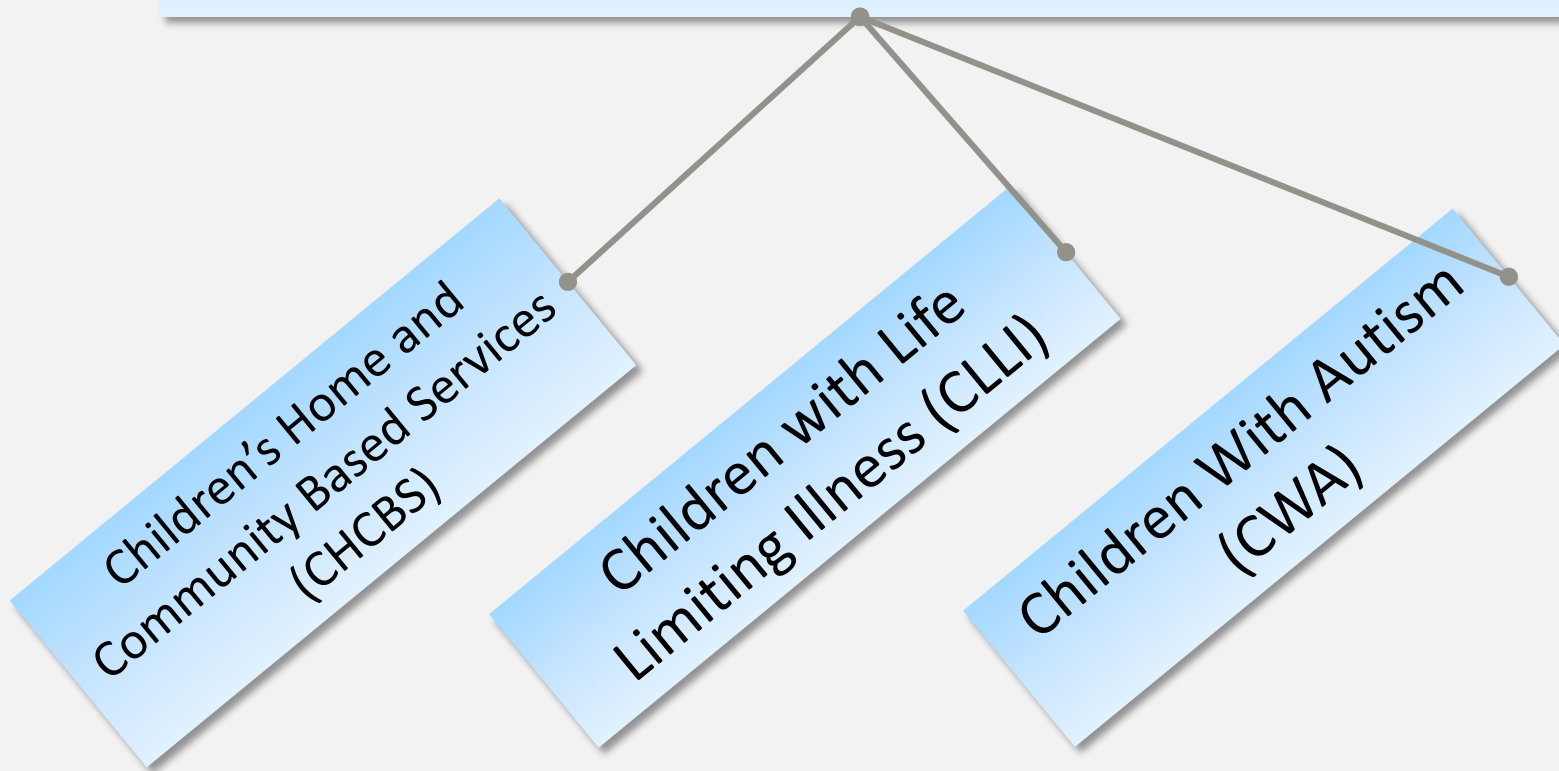
Targeted Case Management (TCM)

- TCM is an optional benefit for members enrolled in the following programs
 - HCBS-DD/Comprehensive Waiver
 - HCBS-SLS (Supported Living Services Waiver)
 - HCBS-CES (Children's Extensive Support Waiver)
 - Early Intervention Services (EI)



Waiver Programs

HCBS Child Waiver Programs



Waiver Programs

Special Program Codes

Program	Modifier	Program Code	Administered By:
CHCBS	U5	88	HCPF
CLLI	UD	97	HCPF
CWA	UL	96	HCPF



HCBS-CHCBS Requirement

- Primary Purpose of Program

- Provides case management & In-Home support services for children who:
 - Are at risk of institutionalization in a hospital or skilled nursing facility
 - And would not otherwise qualify for Colorado Medical Assistance due to parental income and/or resources

- Members Served

- Birth through age 17

- Level of Care Requirements

- Who meet the established minimum criteria for hospital or skilled nursing facility levels of care & who are medically fragile

HCBS-CHCBS Case Management Responsibilities

- ☐ Inform member and/or guardian(s) of the eligibility process
- ☐ Arranges for face-to-face contact w/ member within 30 calendar days of receipt of referral
- ☐ Completes ULTC-100.2
- ☐ Assesses member's health and social needs
- ☐ Develops Prior Approval and Cost Containment Record Form of services and projected costs for State approval
- ☐ Submits a copy of approved Enrollment Form to the County for Colorado Medical Assistance Program State identification number
- ☐ Monitors and evaluates services
- ☐ Reassesses each child
- ☐ Demonstrates continued cost effectiveness, whenever services increase or decrease



HCBS-CLLI Requirement

- Primary Purpose of Program
 - Provides care for children who are at risk of institutionalization in a hospital & have a diagnosis of a life-limiting illness
- Members Served
 - Birth through age 18
- Level of Care Requirements
 - Who meet institutional level of care for inpatient hospitalization



HCBS-CWA Requirement

- Primary Purpose of Program
 - Provides care for children who are at risk of institutionalization and have a medical diagnosis of Autism
- Members Served
 - Birth through age 5
- Level of Care Requirements
 - Who meet institutional level of care for an Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID)



Occurrence Reporting

- Types of Critical Incidents to Report
 - Suspected Abuse, Mistreatment
 - Suspected Neglect
 - Suspected Exploitation
 - All Deaths
 - Serious Illness or Injury
 - Medication Errors
 - Damage or Theft of Member's Property
 - All High Risk Issues
 - All unplanned Hospitalizations



Occurrence Reporting

- HCBS providers who experience a critical incident involving a member enrolled in waiver programs:
 - Are required to report **all** critical incidents to member's case manager within 24 hours of discovery
 - Should also report applicable incidents to appropriate authorities
 - Department of Public Health and Environment
 - Adult or Child Protective Services
 - Local law enforcement



Common Denial Reasons

Timely Filing



Claim was submitted more than 120 days without a LBOD

Duplicate Claim



A subsequent claim was submitted after a claim for the same service has already been paid.

Bill Medicare or Other Insurance



Medicaid is always the “Payor of Last Resort”. Provider should bill all other appropriate carriers first

PAR not on file



No approved authorization on file for services that are being submitted

Total Charges invalid



Line item charges do not match the claim total



Claims Process - Common Terms



Reject

Claim has primary data edits – **not** accepted by claims processing system



Denied

Claim processed & denied by claims processing system



Accept

Claim accepted by claims processing system



Paid

Claim processed & paid by claims processing system

Claims Process - Common Terms



Correcting
under/overpayments,
claims paid at zero &
claims history info

Adjustment



Re-bill previously
denied claim

Rebill



Claim must be
manually reviewed
before adjudication

Suspend



“Cancelling” a
“paid” claim
(wait 48 hours to
rebill)

Void

Adjusting Claims

- **What is an adjustment?**

- Adjustments create a replacement claim
- Two step process: Credit & Repayment

Adjust a claim when:



- Provider billed incorrect services or charges
- Claim paid incorrectly

Do not adjust when:



- Claim was denied
- Claim is in process
- Claim is suspended



Adjustment Methods

Web Portal

- Preferred method
- Easier to submit & track



16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION					
MM		DD		YY	
FROM				TO	
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES					
MM		DD		YY	
FROM				TO	
20. OUTSIDE LAB?			20. \$ CHARGES		
<input type="checkbox"/> YES <input type="checkbox"/> NO					
22. RESUBMISSION CODE			22. ORIGINAL REF. NO.		
23. PRIOR AUTHORIZATION NUMBER					

Paper

- Use Medicaid Resubmission **Reason Code 7** to **replace** a prior claim or **Reason Code 8** to **void/cancel** a claim. The TCN that needs to be **replaced or voided** is the original reference number. Providers will continue to see Reason Code 406 for replacement claims and Reason Code 412 for voided claims on the Provider Claim Reports.

Provider Claim Reports (PCRs)

- Contains the following claims information:
 - Paid
 - Denied
 - Adjusted
 - Voided
 - In process
- Providers required to retrieve PCR through File & Report Service (FRS)
 - Via Web Portal



Provider Claim Reports (PCRs)

- Available through FRS for 60 days
- Two options to obtain duplicate PCRs:
 - Fiscal agent will send encrypted email with copy of PCR attached
 - \$2.00/ page
 - Fiscal agent will mail copy of PCR via FedEx
 - Flat rate- \$2.61/ page for business address
 - \$2.86/ page for residential address
- Charge is assessed regardless of whether request made within 1 month of PCR issue date or not



Provider Claim Reports (PCRs)

Paid

* CLAIMS PAID *

INVOICE	CLIENT	TRANSACTION	DATES OF SVC	TOTAL	ALLOWED	COPAY	AMT OTH	CLM PMT		
NUM	NAME	STATE ID	CONTROL NUMBER	FROM	TO	CHARGES	CHARGES	PAID	SOURCES	AMOUNT
7015	CLIENT, IMA	Z000000	04080000000000000001	040508	040508	132.00	69.46	2.00	0.00	69.46
PROC CODE - MODIFIER 99214 -				040508	040508	132.00	69.46	2.00		
TOTALS - THIS PROVIDER / THIS CATEGORY OF SERVICE				TOTAL CLAIMS PAID		1	TOTAL PAYMENTS			69.46

Denied

* CLAIMS DENIED *

INVOICE	CLIENT	TRANSACTION	DATES OF SERVICE	TOTAL	DENIAL REASONS		
NUM	NAME	STATE ID	CONTROL NUMBER	FROM	TO	DENIED	ERROR CODES
STEDOTCCIOT	CLIENT, IMA	A000000	30800000000000000003	03/05/08	03/06/08	245.04	1348
TOTAL CLAIMS DENIED - THIS PROVIDER / THIS CATEGORY OF SERVICE						1	

THE FOLLOWING IS A DESCRIPTION OF THE DENIAL REASON (EXC) CODES THAT APPEAR ABOVE:

1348 The billing provider specified is not a fully active provider because they are enrolled in an active/non-billable status of '62', '63', '64', or '65' for the FDOS on the claim. These active/non-billable providers can't receive payment directly. The provider must be in a fully active enrollment status of '60' or '61'. COUNT 0001

Provider Claim Reports (PCRs)

Adjustments

Recovery

***** * ADJUSTMENTS PAID * *****										
INVOICE --- CLIENT	-----	TRANSACTION	DATES OF SVC	ADJ	TOTAL	ALLOWED	COPAY	AMT OTH	CLM PMT	
NUM ----- NAME -----	STATE ID	CONTROL NUMBER	FROM	TO RSN	CHARGES	CHARGES	PAID	SOURCES	AMOUNT	
Z71	CLIENT, IMA	A000000	40800000000100002	041008	041808 406	92.82-	92.82-	0.00	0.00	92.82-
PROC CODE - MOD T1019 - U1			041008	091808		92.82-				
Z71	CLIENT, IMA	A000000	40800000000200002	041008	041808 406	114.24	114.24	0.00	0.00	114.24
PROC CODE - MOD T1019 - U1			041008	041808		114.24				
NET IMPACT						21.42				

Repayment

Net Impact

Voids

* ADJUSTMENTS PAID *

INVOICE - CLIENT -----			TRANSACTION DATES OF SVC		ADJ	TOTAL	ALLOWED	COPAY	AMT OTH	CLM PMT	
NUM -----	NAME -----	STATE ID	CONTROL NUMBER	FROM	TO	RSN	CHARGES	CHARGES	PAID	SOURCES	AMOUNT
A83	CLIENT, IMA	Y000002	40800000000100009	040608	042008	212	642.60-	642.60-	0.00	0.00	642.60-
PROC CODE - MOD T1019 - U1				040608	042008		642.60-	642.60-			
NET IMPACT							642.60-				



Provider Services

Xerox

1-800-237-0757

Claims/Billing/ Payment

Forms/Website

EDI

Enrolling New Providers

Updating existing provider profile

CGI

1-888-538-4275

Email helpdesk.HCG.central.us@cgi.com

CMAP Web Portal technical support

CMAP Web Portal Password resets

CMAP Web Portal End User training

Thank You!

